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CHAPTER TWENTY

THIRD PARTY

Chapter 20. Third Party

Rule No. 560-X-20-.01 Third Party Program

(1) General

(a) Third Party Division (TPD), Alabama Medicaid Agency, is responsible for fulfilling the requirements pertaining to third party liability. The purpose of the TPD is to insure that Medicaid is the last payor.

(b) Third party resources are primary to Medicaid.

(c) Federal law requires that state Medicaid agencies take all reasonable measures to identify third party resources which may have legal/fiscal/contractual liability as a result of medical assistance furnished to a Medicaid recipient.

(d) Where third party liability is known or reasonably expected, the Medicaid Agency may require providers to collect third party resources prior to filing Medicaid.

(e) Where Medicaid payment has not been reduced by third party benefits, the Medicaid Agency is required to take reasonable measures to collect from third parties the cost of medical assistance furnished to Medicaid recipients to the extent that the third party may have legal/fiscal/contractual liability.

(f) Claims for services which are filed with Medicaid and paid in full or in part by a third party will be applied against program benefit limitations.

(g) A provider may not refuse to furnish services covered under the plan to an individual who is eligible for Medicaid under the plan due to a third party's potential liability for the service(s).

(2) Definitions

(a) Third Party - Any individual, entity or program that is or may be liable (contractually or otherwise) to pay all or part of the medical cost of any medical assistance furnished to a recipient under a State plan.

(b) Private insurer - a third party which may be:

1. Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

2. Any profit or nonprofit prepaid plan (including, but not limited to, subscription plans) offering either medical services or full or partial payment for services included in the State Plan;

3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

(c) Employer Drug Program - A specific program offered through a group health plan which provides benefits for prescription drugs. The program covers the prescription in full if provided by a pharmacist participating in the program; there is a co-payment required of the insured for prescriptions received from a non-participating pharmacy. The drug program pays directly to pharmacies which participate in the program; it pays benefits to the insured for prescriptions dispensed by a non-participating pharmacy. Under this program a drug card is issued through the group plan to the insured.

(d) Third party benefit - any benefit that may be available at any time through contract, court award, judgment, settlement, or agreement.

Authority: 42 CFR Section 432, 433, and 447.20; Section 1902(a)(25), Social Security Act; Section 22-6-6, Code of Alabama, 1975. Rule amended March 11, 1985, October 9, 1985, March 24, 1986, June 9, 1986, and January 13, 1993. This amendment effective July 13, 1993.

Rule No. 560-X-20-.02. Third Party Recovery

(1) General

(a) All providers must file claims with a third party as specified by this rule.

(b) Providers must file claims with a primary third party within sufficient time for the third party to make payment. If the provider has difficulty obtaining a response from the third party or with the processing of Medicaid claims due to Third Party procedures, the provider should contact the Third Party Division, Alabama Medicaid Agency.

(c) An aged, outdated claim which is timely submitted to Medicare or another third party must be received by the fiscal agent within one hundred twenty (120) days of the notice of the disposition of such claim to the provider.

(d) Providers cannot file with Medicaid until the third party responds. Exception: Providers may file Medicaid and Medicare simultaneously if the Medicare intermediary crosses over claims to the Medicaid fiscal agent.

(2) Health Insurance Resources

(a) All providers (except as excluded through HCFA - approved cost avoidance waivers) are required to file for and obtain available third party health insurance benefits for all services except those excluded from cost avoidance requirements by federal regulations.

(b) Claims for services exempted by federal regulations from cost avoidance will not be denied by Medicaid due to available third party resources when the provider does not file with the third party. Such claims will be filed with the third party by the Medicaid Agency which will seek reimbursement of its payment from the third party.

(c) HCFA has approved a cost avoidance waiver for prescription drug claims; therefore, pharmacy providers are required to file for third party health insurance benefits prior to filing Medicaid only when

1. the recipient is covered through a prescription drug plan of an employer group health insurance program. (See Rule No. 560-X-20-.01.); or

2. the recipient's prescriptions are covered by the Veterans Administration.

3) Casualty and Other Third Party Resources

(a) All providers are required to file for liability insurance and other third party benefits if the recipient is insured with the plan as well as for worker's compensation benefits.

(b) The Third Party Division, Alabama Medicaid Agency, will file for third party benefits in situations where there is a third party other than the recipient's insurance and

an injury is involved. Medicaid will file for casualty related resources to insure that all related medical care paid by Medicaid will be considered in a settlement.

(c) If a provider files with a third party resource other than the recipient's own insurance, the provider must notify the Third Party Division, Alabama Medicaid Agency, within five days of filing with the third party.

(d) Providers may file liens when there are charges not covered by Medicaid; however, the provider must furnish to the Third Party Division, Alabama Medicaid Agency, complete information about the lien within five days of filing the lien.

Authority: 42 CFR Section 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama; 42 CFR Section 447.45; Title XIX, Social Security Act. Rule effective October 1, 1982. Amended March 11, 1985, April 11, 1986, May 11, 1987. Effective date of this amendment January 13, 1993.

Rule No. 560-X-20-.03. Documentation of Third Party Resources

(1) The Claim

(a) All providers are required to question Medicaid recipients to obtain information about third party resources which may pay as a result of medical services provided to the recipient. All providers must complete third party fields on the Medicaid claim, including stating the name, address, and policy number of any third party resource.

(2) Form XIX-TPD-1-76

(a) All providers except as noted herein are required to submit a completed Form XIX-TPD-1-76 with their Medicaid claim if one or more of the following conditions are met:

1. Treatment was due to an injury
2. There is a third party resource not billed by the provider.

(b) Radiologists, Pharmacists, Pathologists, Ambulance providers, Anesthesiologists, Nursing Homes, Home Health agencies, and Children's Rehabilitation Services providers are not required to submit form XIX-TPD-1-76 with their claims.

(c) Form XIX-TPD-1-76 is not required if treatment is due to disease or a home injury where there is no potential third party liability; however, the claim must state "home injury" or "treatment due to disease". Injuries received by a patient in a nursing home are not home injuries.

(3) The Medicaid Eligibility File

(a) The Third Party Division, Alabama Medicaid Agency, is required to show the existence of third party health insurance resources on the Medicaid Eligibility File. These codes are used in claims processing.

(4) The Policy File

(a) The Third Party Division, Medicaid, maintains a Policy File which identifies specific coverage provided by a recipient's health insurance.

(5) AVRS and MACSAS

(a) Third party benefit data is maintained on Medicaid's Automated Voice Response System and the Medicaid Automated Claim Submission and Adjudication

System for inquiry by providers. Providers should access either system for third party health insurance information prior to filing Medicaid.

Authority: 42 C.F.R. Section 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama. Effective date of this amendment January 13, 1993.

Rule No. 560-X-20-.04. Third Party Payments/Denials

(1) Third Party Payments other than Medicare

(a) Third Party payments must be applied to the services for which the third party paid.

(b) Providers receiving a third party payment prior to filing Medicaid must document in the appropriate field on the claim the amount of the third party payment.

(c) Providers receiving a third party payment after Medicaid is filed must within 60 days of receiving duplicate payment:

1. send a refund of the insurance money to the Third Party Division, Alabama Medicaid Agency; or

2. write the Medicaid fiscal agent and request an adjustmentof Medicaid payment (a copy of the request MUST be sent to the Third Party Division, Alabama Medicaid Agency).

(d) If the third party pays the recipient or source other than the provider, the provider is responsible for obtaining the third party payment prior to filing Medicaid. The provider is responsible for reimbursing Medicaid if a third party pays the recipient or source other than the provider for Medicaid covered services if the third party makes payment as a result of information released by the provider.

(e) If the provider accepts a patient with a third party resource as Medicaid the provider cannot bill the patient for Medicaid covered services if:

1. the third party pays more than Medicaid allows which results in Medicaid not making payment.

2. the claim is denied by Medicaid because of third party resources and the recipient furnishes in a timely manner third party information.

(f) A provider may bill a Medicaid patient if Medicaid denies a claim because of available third party benefits and the provider cannot obtain information needed to file a third party claim from the recipient, AVRS, MACSAS or the Medicaid Agency.

(2) Third Party Payments - Medicare

(a) Providers must attach a copy of the Medicare EOMB to the Medicaid claim.

(b) Within 60 days of receiving duplicate Medicaid and Medicare payments the provider must:

1. Refund the Medicaid payment to the Medicaid fiscal agent and state the reason for the refund; or

2. Request that the Medicaid fiscal agent adjust the Medicaid claim.

(3) Third Party Denials

(a) Providers must attach third party denials of benefits to their Medicaid claim when filing for Medicaid benefits. These claims must be filed as paper claims.

(b) Providers must state on the Medicaid claim "Denied by Third Party" if third party benefits are denied.

(c) Only true denials of benefits are acceptable, i.e., policy has lapsed, benefits applied to deductible, non-covered services, etc.

(4) Questions regarding third party payment/denials should be referred to the Third Party Division, Alabama Medicaid Agency.

Authority: 42 C.F.R. Sections 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama. Effective date of this amendment January 13, 1993.

Rule No. 560-X-20-.05. Release of Information - All Providers

(1) Information pertaining to a patient's treatment (including billing statement, itemized bills, etc.) may be routinely released ONLY UNDER THE FOLLOWING CIRCUMSTANCES AND/OR TO THE FOLLOWING AGENCIES if Medicaid has been billed or is expected to be billed:

(a) The Medicaid Fiscal Agent,

(b) The Social Security Administration,

(c) The Alabama Vocational Rehabilitation Agency,

(d) The Alabama Medicaid Agency,

(e) Requests from insurance companies for information pertaining to a claim filed by the provider in accordance with Medicaid Regulations and for which an assignment of benefits to the provider was furnished the insurance company.

(f) Requests by insurance companies for information to process an application for insurance, to pay life insurance benefits, or to pay on a loan.

(g) Requests from other providers for medical information needed in the treatment of patient.

(2) If information pertaining to a patient's treatment is requested by any other source, or under any other circumstance, the Alabama Medicaid Agency, Third Party Section, must be contacted PRIOR TO RELEASE OF INFORMATION. The only exception is when a subpoena is received during nonworking hours of the Alabama Medicaid Agency and must be responded to immediately. Should this occur, the provider may respond to the subpoena and must include with the released records a notice that the patient was covered by Medicaid. In addition, the provider must notify the Third Party Section of the subpoena as soon as possible.

(3) It is not the intention to deny release of information; however, requests for information pertaining to a recipient's charges are a source of third party information and, as such, must be reviewed by the Third Party Section.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Section 22-6-6 of 1975 Code of Alabama.

Rule No. 560-X-20-.06. Fiscal Agent Responsibility.

(1) The fiscal agent is responsible for monitoring all claims for possible third party liability and utilizing information on the face of the claim, Form XIX-TPD-1-76, the Eligibility file, the Insurance Policy File, and Diagnostic Codes to identify potential third party liability.

(2) The fiscal agent is responsible for retroactively identifying third party liability on a regular basis.

(3) Where it is determined a recipient is retroactively eligible for Medicare, the fiscal agent will recoup erroneous Medicaid payment from the provider and instruct the provider to file with Medicare.

Authority: 42 C.F.R. Sections 432 & 433; Section 1902(a)(25), Social Security Act; Section 22-6-6 of 1975 Code of Alabama.

Rule No. 560-X-20-.07. Recipient Responsibility.

(1) The Alabama Medicaid Agency by statute is subrogated to the rights of a Medicaid recipient against any third party arising out of injury, disease, or sickness. The recipient is required to assist and cooperate fully with Alabama Medicaid Agency in its effort to secure such rights including the requirement to:

(a) Notify Alabama Medicaid Agency within ten days of filing suit against a third party;

(b) Notify Alabama Medicaid Agency, Third Party Section, prior to entering any settlement with a third party;

(c) Immediately pay to Alabama Medicaid Agency all funds received from any third party to the extent necessary to satisfy the subrogation rights of the State of Alabama;

(d) Disclose information regarding health insurance or other third party resources when applying for Medicaid;

(e) Notify providers of medical care of health and casualty coverage and other third party resources when requesting medical care;

(f) Notify Alabama Medicaid Agency of any health insurance obtained after becoming eligible for Medicaid;

(g) Notify Alabama Medicaid Agency, Third Party Section, of any casualty/liability insurance which may cover medical treatment received due to an injury;

(h) Execute and deliver all instruments and papers needed by Alabama Medicaid Agency in pursuit of its subrogation claim.

(2) The State of Alabama by statute is assigned any and all rights to payments by any person, firm or corporation which result from medical care received by the recipient, together with the rights of any other individuals eligible for Medicaid for whom he can make assignment. This assignment shall be effective to the extent of the amount of medical assistance actually paid by the Agency and shall, effective 11/9/84, exclude

Medicare. The recipient is required to assist and cooperate fully with Alabama Medicaid Agency in its effort to secure such rights.

(3) Failure of the applicant or recipient to cooperate with the Medicaid Program to secure its rights to subrogation and assignment may result in denial or termination of Medicaid eligibility. Recipients terminated under this Rule will be notified in writing of the agency action and afforded the opportunity for a Fair Hearing under the provisions of Chapter 3 of these Rules.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Code of Alabama Sections 22-6-6 & 22-6-6.1. Rule effective October 1, 1982. Effective date of amendment February 9, 1987.

Rule No. 560-X-20-.08. Payment of Health Insurance Premiums

(1) The Alabama Medicaid Agency may pay health insurance premiums of certain Medicaid eligibles or recipients when the Agency determines that payment of the premium would be cost effective. The primary objective of paying certain health insurance premiums is to reduce Medicaid expenditures by enrolling Medicaid eligibles in or continuing existing health insurance coverage so that Medicaid becomes a secondary payor.

(2) Cost effectiveness is defined as meaning the expenditure of Medicaid funds for a set of services is likely to be greater than the cost of paying the health insurance premium. Criteria for determining cost effectiveness will be determined by the Alabama Medicaid Agency.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Consolidated Omnibus Reconciliation Act of 1985; Section 4402 of the Omnibus Reconciliation Act of 1990. Emergency rule effective April 1, 1991. Effective date of this amendment August 16, 1991.